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Exploring Concepts of Gender and Health

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Exploring Concepts of Gender and Health

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1 Gender-based Analysis – A Catalyst for Change

Being male or female has a profound impact on our health status, as well as our access to and use of health services. At Health Canada, gender-based analysis (GBA) is being integrated as a tool in the research-policy-program development cycle to better illustrate how gender affects health throughout the lifecycle—and to identify opportunities to maintain and improve the health of women and men, girls and boys in Canada. As such, GBA supports the development of health research, policies, programs and legislation that are fair and effective, and are consistent with government commitments to gender equality (see Section 2).

What Is Gender-based Analysis?

GBA is a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men (Status of Women Canada, 1996). In the context of health, the *integrated* use of GBA throughout the research, policy and program development processes can improve our understanding of sex and gender as determinants of health, of their interaction with other determinants, and the effectiveness of how we design and implement sex- and gender-sensitive policies and programs. Ultimately, GBA brings into view the influences, omissions and implications of our work.

Why Is Gender-based Analysis Important?

A catalyst for change, GBA ensures that a gender equality perspective is taken into account throughout the research, policy and program development processes. Used effectively and consistently, GBA "makes for good science and sound evidence by ensuring that biological and social differences between women and men are brought into the foreground" (Health Canada, 2000b).

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GBA can be used to understand issues concerning:

- different population groups (e.g. First Nations, rural residents, seniors, immigrants, visible minorities, refugees)
- certain behaviours (e.g. tobacco use, physical activity, violence, intravenous drug use)
- the health care system (e.g. primary health care, privatization, health reform)
- diseases and illnesses (e.g. cardiovascular disease, cancer, HIV/AIDS, mental illness)

Within Health Canada, GBA is designed to promote sound scientific research, and provide relevant health information and evidence, with the goal of enhancing health outcomes and strengthening health care.

Gender-based Analysis and the Population Health Approach

GBA is consistent with Health Canada's population health approach, which recognizes that health is determined not solely by health care and personal health choices, but also by other factors. Health Canada recognizes that the determinants of health, including income and social status, employment, education, social environments, physical environments, healthy child development, personal health practices and coping skills, health services, social support networks, *biology and genetic endowment* (sex), *gender* and culture, all influence health and Canadians access to, and benefits from, the health system.

Population health strategies are designed to affect whole groups or populations of people—in the case of GBA, men and women. The interrelated conditions and factors that influence the health of the population over the lifespan are the focus of this approach. Systematic variations in their patterns of occurrence are identified and the resulting knowledge applied to improve health and well-being.

About This Guide

Exploring Concepts of Gender and Health advances Health Canada's commitment to fully implement GBA throughout the department. One of several capacity-building tools developed by Health Canada's Women's Health Bureau, it suggests ways for researchers, policy analysts, program managers and decision makers to integrate GBA into their day-to-day work. This guide includes:

- an overview of government commitments
- key concepts in GBA
- how to integrate GBA within the research-policy-program development cycle
- case studies to demonstrate in concrete terms how GBA can be a catalyst for change
- references and sources of further reading
- a comprehensive list of information and resources—provincial, national and international—related to gender and health
- a discussion of GBA and social trends
- policies and measures that outline the basis for all Canadians to be treated equally

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How Being Male or Female Affects Your Health

These examples illustrate how being male or female affects health, and suggest how this information can lead to new questions and research. Some of the examples point to sex or biologically based differences, while others refer to differences associated with gender—the socially constructed roles ascribed to men and women.

Did you know?

- The same drug can cause different reactions and different side effects in women and men—even common drugs like antihistamines and antibiotics (Makkar et al., 1993).

  Are all drugs to be used by both men and women tested for their potentially different effects on both sexes before seeking market approval?

- Females are more likely than males to recover language ability after suffering a left-hemisphere stroke (Shaywitz et al., 1995).

  How can additional brain research help us improve the outcomes for men, based upon what we already know about how the female brain processes language?

- During unprotected intercourse with an infected partner, women are two times more likely than men to contract a sexually transmitted infection and ten times more likely to contract HIV (Society for Women's Health Research, 2001).

  What can be done to reduce women's risk of contracting sexually transmitted infections?

- The death rate from suicide is at least four times higher for men than it is for women. However, women are hospitalized for attempted suicide at about one and a half times the rate of men (source for both: Langlois and Morrison, 2002).

  Are there differences between men and women in how they respond to stress and reach out for help? What preventive measures can we take that are sensitive to these differences?

- Women who smoke are 20 to 70 percent more likely to develop lung cancer than men who smoke the same number of cigarettes (Manton, 2000; Shriver et al., 2000).

  What is it about female physiology that accounts for this difference?

- For Aboriginal women, the rate of diabetes is five times higher than it is for all other women in Canada; for Aboriginal men, the rate is three times higher (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

  How can programs aimed at decreasing the incidence of diabetes take this knowledge into account?

- In 2000, 70 percent of all persons aged 85 or over were female (Health Canada, 2001b). While women live longer than men, they are more likely to suffer from long-term activity limitations and chronic conditions such as osteoporosis, arthritis and migraine headaches (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

  How can policies and programs accommodate the health needs of the growing number of senior women in this country?

2 Foundations of Gender-based Analysis

GBA builds on a number of domestic and international commitments to gender equality.

Legal Foundations

Gender equality in Canada is guaranteed through the Constitution, under Sections 15(1) and 28 of the *Canadian Charter of Rights and Freedoms* and by the many international human rights instruments to which Canada is signatory.

International and Domestic Commitments

In 1981, Canada ratified the United Nations *Convention on the Elimination of All Forms of Discrimination Against Women*, which outlines women's human rights through ensuring women's equal access to, and equal opportunities in, political and public life, as well as education, health and employment.

In 1995, Canada adopted the *United Nations Platform for Action*, the concluding document of the United Nations World Conference on Women in Beijing.[1] It was at that conference that the Government of Canada presented its national action plan to further advance the status of women. The ***Federal Plan for Gender Equality*** (1995–2000) states that all subsequent legislation and policies will include, where appropriate, an analysis of the potential for differential impacts on men and women. The first of the Federal Plan's eight objectives made a commitment to government-wide implementation of gender-based analysis in the development of policies, programs and legislation. Chapter 3 of the Federal Plan, "Improving the Health and Well-being of Women," discussed issues pertinent to the health situation of women in Canada and committed to the implementation of a women's health strategy.

Building on the foundation of actions taken under the Federal Plan, the federal government approved the ***Agenda for Gender Equality*** in 2000 as a government-wide initiative to advance women's equality. Key components include engendering current and new policy and program initiatives and accelerating implementation of gender-based analysis commitments. The *Agenda for Gender Equality* is led by Status of Women Canada, in cooperation with three other federal departments: Health Canada, the Department of Justice Canada and Human Resources Development Canada.

Several federal departments have issued formal gender-based analysis guidelines, including the Canadian International Development Agency, Human Resources Development Canada, the Department of Justice Canada and Status of Women Canada.[2] Health Canada's commitment is embodied in the *Women's Health Strategy* (1999b) and *Gender-based Analysis Policy* (2000b).

[1] http://www.un.org/womenwatch/daw/beijing/platform/declar.htm
[2] For international, national and provincial resource information see Section 11 of this guide.

Health Canada Commitments

Health Canada's ***Women's Health Strategy*** provides the framework for the department's approach to incorporating gender-based analysis into its work.

The Women's Health Strategy states that Health Canada will apply GBA to programs and policies in key areas of the department, including health system modernization, population health, risk management, direct services and research.

The *Women's Health Strategy* states that Health Canada will apply GBA to programs and policies in key areas of the department, including health system modernization, population health, risk management, direct services and research. Gender is recognized as a determinant of health, one of twelve within a population health approach (Health Canada, 1999b). This recognition "supports gender equality in the health system" (Health Canada, 2000b).

The Strategy supports the global recognition that the health system should accord women and men equal "treatment," in every sense of the word, and should strive to attain equitable outcomes for both.

The ***Gender-based Analysis Policy*** explains why and how Health Canada is integrating GBA into the day-to-day work of the department.

(For more detailed information about important policies and legislative measures, see Appendix 1.)

Women's Health Bureau

In 1993, Health Canada established the Women's Health Bureau to ensure that women's health concerns receive appropriate attention and emphasis within the department. The Women's Health Bureau is responsible for implementing the *Women's Health Strategy* and *Gender-based Analysis Policy* within Health Canada, and acts as the focal point for women's health in the federal government. The Bureau also manages the Women's Health Contribution Program to support policy research and education in women's health.

Women's Health Contribution Program

Established in 1995, the Women's Health Contribution Program (WHCP) currently provides support to four Centres of Excellence for Women's Health, the Canadian Women's Health Network and other initiatives.

In 1996, the **Centres of Excellence for Women's Health** were established to inform the policy process and narrow the knowledge gap on sex, gender and the other health determinants.[3] The Centres are multidisciplinary partnerships of academic and community researchers and community-based organizations. The Centres address the gaps

[3] See Section 11 of this guide for contact information. Online information is available at http://www.cewh-cesf.ca

in knowledge regarding the determinants of health, with particular attention paid to the ways that sex and gender affect health and interact with other determinants of health.

The **Canadian Women's Health Network** (CWHN) represents more than 70 organizations from all provinces and territories. CWHN supports communications activities of the Centres of Excellence for Women's Health and other WHCP initiatives, and is the women's health affiliate of the Canadian Health Network, a nationally funded Internet-based service designed to improve access to accurate and reliable health information.

Other initiatives: As well as specific research projects such as the Aboriginal Women's Health and Healing Research Group, the program also currently supports two working groups: Women and Health Protection and the National Coordinating Group on Health Reform and Women.

Health Canada also collaborates with the Canadian Institutes of Health Research **Institute of Gender and Health** (IGH). The IGH supports research to address how sex and gender interact with other factors that influence health to create conditions and problems that are unique, more prevalent, more serious or different with respect to risk factors or effective interventions for women and for men.[4]

In addition to these government commitments and policies, several key concepts are important to understanding GBA. These are discussed in the next section.

[4] For additional information on the Canadian Institutes of Health Research, see http://www.cihr.ca

3 Key Concepts in Gender-based Analysis

The following definitions of key concepts elaborate on those already adopted in Health Canada's *Gender-based Analysis Policy* (2000b).

SEX

Sex refers to the biological characteristics such as anatomy (e.g. body size and shape) and physiology (e.g. hormonal activity or functioning of organs) that distinguish males and females.

To improve health status, we need evidence on how sex differences (e.g. biochemical pathways, hormones and metabolism) offer insights into possible biological and genetic differences in susceptibility to diseases (e.g. heart disease, lung cancer) and responses to treatment.

The health sector is slowly recognizing the extent of anatomical and physiological differences between males and females and incorporating these differences in science and treatment (e.g. in recognizing and treating heart disease and in understanding the different effects of anaesthetics) (Health Canada, 2000b).

GENDER

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gender is relational and refers not simply to women or men but to the relationship between them (Health Canada, 2000b). All societies are divided along the "fault lines" of sex and gender (Papanek, 1984) such that men and women are viewed differently with respect to their roles, responsibilities and opportunities, with consequences for access to resources and benefits.

The legal concept of "substantive equality" reflects the importance of ensuring not only equality of opportunity but also equality of outcome. GBA is about substantive equality.

Formal and Substantive Equality

The term "equality" has usually been used to emphasize similarities between people. The legal concept of "formal equality" requires that people in the same or similar circumstances be treated the same. Historically, treating people equally was understood to mean giving women and men the same opportunities, services and programs. Sometimes, however, different treatment may be required to achieve fairness and justice when differences between people cause disadvantages and inequality. The legal concept of "substantive equality" reflects the

importance of ensuring not only equality of opportunity but also equality of outcome. GBA is about substantive equality.

Diversity Analysis

Health Canada's *Gender-based Analysis Policy* (2000b) states that the GBA framework should be overlaid with a diversity analysis. Diversity analysis is a process of examining ideas, policies, programs and research to assess their potentially different impact on specific *groups* of men and women, boys and girls. Neither women nor men comprise homogeneous groups. Class or socio-economic status, age, sexual orientation, gender identity, race, ethnicity, geographic location, education, physical and mental ability—among other things—may distinctly affect a specific group's health needs, interests and concerns. Much research remains to be done to identify important differences and commonalities among men and among women with regard to health status, experiences of the health system, health behaviour and other determinants of health.

Population Health

As described earlier in this guide, the population health approach concerns itself with the entire population or large subgroups and rests on a body of research demonstrating that a combination of personal, social and economic factors, in addition to health services, play an important role in achieving and maintaining health.

Sex/Gender-sensitive Health Research

Sex/gender-sensitive health research investigates how *sex interacts* with gender to create health conditions, living conditions and problems that are unique, more prevalent, more serious, or for which there are distinct risk factors or interventions for women or men. It is possible to disaggregate data based on sex and/or gender without putting the data in context. Similarly, a proper analysis of sex-disaggregated data is sometimes ignored in the development of policy or programs emanating from research and evaluation. In contrast, sex/gender-sensitive research entails a comprehensive analysis and assessment of the findings and the impact of recommendations on diverse groups of men and women.

Gender Mainstreaming

The term "gender mainstreaming" came into widespread use through the *United Nations Platform for Action* (see footnote 1). It refers to the integration of gender concerns into policy making and research so that policies and programs reduce inequalities between women and men (World Health Organization, 1998). ***Gender-based analysis*** is a gender mainstreaming tool that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men.

4 Integrating Gender-based Analysis into Research, Policy and Program Development

Research, policy and program development are inextricably linked. Through an iterative process, each builds on and constrains the other, depending on the other for accuracy, inclusiveness and acceptability. Gender bias in any of these activities has implications for the others, as well as for the ultimate beneficiaries of the government's initiatives—the women and men, girls and boys of Canada.

The objectives of GBA are substantive equality, responsiveness to diversities and the meaningful engagement of a wide range of stakeholders at all stages of decision making.

The interlocking nature of these activities and these contexts requires that GBA be a constant thread in existing analyses or in a strategy to be put into action only once (Council of Europe, 1998). Done well, GBA *systematically* informs the processes of conducting research and program evaluation, the outcomes of which determine policies, programs and legislation. Its objectives are substantive equality, responsiveness to diversities and the meaningful engagement of a wide range of stakeholders at all stages of decision making. Depending on the policy environment, priorities may change, but GBA remains an integral dimension of government decision making.

Integrating the gender perspective

GBA is not an add-on, but is integrated into each step of the research-policy-program-development process.[5] Consideration of sex and gender allows for more meaning to be absorbed from the actions we take, the policy instruments and research methods we choose, the diverse groups of women and men we consult and our knowledge of the determinants of health.

Responding to diversity

Gender does not operate in isolation, but in relation to other factors such as race, ethnicity, level of ability, age, sexual orientation, gender identity, geographic location and education. Therefore, GBA should also be overlaid with a diversity analysis, which allows us to see how a program or policy may affect the distinct health needs of specific groups of women and men.

[5] For step-by-step suggestions about how to incorporate GBA into the research-policy-program development process, see Sections 5 and 6 of this guide.

Understanding trends

As a contextualized tool, GBA considers the impact of past, current and emerging social patterns and trends on sex and gender (see Appendix 2). Congruent with a population health approach, GBA recognizes that health arises in the everyday conditions of life: knowledge of these diverse conditions and social trends and how they change over time is especially important for policy and program development.

Incorporating GBA into government decision making

GBA is, like most "new products," incorporated into an already existing framework. In this case, the framework is made up of dynamic and interlocking processes and mechanisms used in government decision making. We also need to consider historic events, current government direction, length of the government's term in office, and prior policy directions and commitments. These factors constrain or widen our perspective, the parameters of our actions, and our understanding of health.

Inclusive research and consultation

GBA also increases substantive equality by involving a wide range of stakeholders in decision making and by using the widest array of evidence possible. Opportunities for citizens to talk with one another and with decision makers lead to mutual learning, which, in turn, leads to more effective policy (Policy Research Initiative, 2002). In research, the use of both quantitative and qualitative methods, and participatory methods that involve those who are being researched in setting the research question and vetting the process and reporting of research, can significantly enrich our pictures of health. Policy making and program planning are also enriched by getting more people into the picture to identify issues and suggest options.

The next section of this guide suggests how to integrate GBA into the research process.

5 The Research Process and Gender-based Analysis

Research is an important tool for reducing gender biases in policy development and program planning. The exclusion of sex and gender as variables in any type of health research is a serious omission that leads to problems of validity and generalizability, weaker clinical practice and less appropriate health care delivery (Greaves et al., 1999).

Research needs to be conducted in ways that are sensitive to manifestations of sex and gender, or it may perpetuate rather than illuminate sex and gender biases.

Research needs to be conducted in ways that are sensitive to manifestations of sex and gender, or it may perpetuate rather than illuminate sex and gender biases. Research on sex, gender and health may also suffer from significant shortcomings. These include:

- treating sex like any other variable and failing to put it into context
- assumptions about gender neutrality and the consequent failure to provide gender-sensitive research
- treating sex and gender as the same thing
- failing to disaggregate data based on sex
- failing to analyze sex-disaggregated data
- failing to report the results of sex-disaggregated data analyses
- the relegation of qualitative data to a supplementary role, defining it as having merely anecdotal value (Grant, 2002)

Consideration of the following questions at each stage of the research process should help reduce gender bias in the research process.[6]

Formulate Research Questions

- Does the research question exclude one sex when the conclusions are meant to be applicable to both sexes? *If yes, reformulate the question so that it is applicable to both sexes or so that it is applicable to only one sex.*
- Does the research question exclude one sex in areas that are usually seen as particularly relevant to the other, such as family and reproductive issues in research about men or paid work in research about women? *If yes, give attention to the role of the other sex.*
- Does the research question take the male as the norm for both sexes, thereby restricting the range of possible answers? *If yes, reformulate the question to allow for the theoretically possible range.*

[6] This series of research questions is adapted from Dr. Margrit Eichler, "Moving Toward Equality: Improving the Health of All People: Recognizing and Eliminating Gender Bias in Health," Health Canada (draft), Women's Health Bureau, 2000c. Permission is granted for non-commercial reproduction of this adaptation on condition that Dr. Margrit Eichler is clearly acknowledged as the author. For a fuller discussion, refer to Dr. Margrit Eichler, Feminist Methodology, *Current Sociology*, April 1997, Vol. 45(2): 9–36.

- Does the research question take the family or household as the basic analytical unit when different consequences for women and men within the family or household can be anticipated? *If yes, change the question so that the unit of analysis corresponds to the level at which observations are made.*
- Is the research question different for the two sexes though their circumstances are equivalent? *If yes, reformulate the question.*
- Does the research question assume that men and women are homogeneous groups when the impact of the health issues being studied may be different for different groups of men and women? *If yes, explore differences among the men and among the women, not just those between the men and the women.*
- Does the research question construct men as actors and women as acted upon? *If yes, explore the role of women as actors and of men as acted upon.*

Literature Review

- Does the phenomenon under consideration affect both sexes? If so, does the literature give adequate attention to each sex? *If no, note the under-represented or excluded sex.*
- Have studies concerning family roles and reproduction given adequate attention to the role of men? In all other studies in the literature being reviewed, has the role of women been given adequate attention? Are different types of families taken into account? *If no, compensatory studies on the under-represented or excluded sex may be necessary before drawing conclusions.*
- Does the literature address issues of diversity among women and men? *If no, note the exclusions and limits of the literature.*

Research Design

- If the phenomenon under investigation affects both sexes, does the research design adequately represent both sexes? *If no, include the under-represented or excluded sex. If the balance of previous research has largely excluded one sex, a one-sex study may be highly appropriate.*
- Of the major variables examined in the study, are they equally relevant to men and women? To women and men from a variety of diverse groups? Is the diversity within subgroups identified and analyzed? *If no, correct the imbalances by including variables that affect the under-represented group.*
- Does the study take into account the potentially different life situations of men and women? *If no, explore the context in a gender-sensitive manner.*
- When dealing with issues that affect families or household, is it possible that the event, issue, attribute, behaviour, experience or trait may be different for different family members. *If yes, identify and study separately individual actors with a view for potential gender differences. This may involve a drastic revision of the research design.*
- Is the same research focus, method or approach used for both females and males? If not, is the different focus, method or approach justified? *If no, provide a detailed rationale.*

- Is the sex of all participants in the study, including researchers and research staff, reported and controlled for? *If no, report and control where possible and necessary. Where not possible, acknowledge and discuss the potential distorting effects of the sex of the various research participants.*

Research Methods and Data Gathering

- Has the research instrument been validated on diverse groups of both sexes? *If different instruments are used without compelling reasons, develop an instrument that is applicable to both sexes and to diverse groups of both sexes. If different instruments are necessary, justify their use in detail.*
- Does the research instrument take one sex (race, class, etc.) as the norm for both sexes and thus restrict the range of possible answers? *If yes, reformulate the instrument to allow for the theoretically possible range.*
- Are opinions asked of one sex about the other treated as fact rather than opinion? *If yes, reinterpret other-sex opinions as statements of opinion and no more.*
- Are the same coding procedures used for males and females? *If no, make coding procedures identical.*

Data Analysis and Interpretation

- If only one sex is being considered, are conclusions nevertheless drawn in general terms? *If yes, make conclusions sex-specific where only one sex is considered, or change the research design and consider both sexes.*
- Are data interpreted by taking males as the norm? *If yes, take females as the norm and compare the two.*
- Are practices that abuse or subjugate women or negate their human rights presented as culturally appropriate or justified in the name of a supposedly higher value? *If yes, describe and analyze such practices but do not excuse or justify them.*
- Does the analysis pathologize normal female biological processes or normalize male biological processes? *If yes, create alternative accounts.*
- Have the potentially different implications for the two sexes of the particular situation, condition or event under investigation been made explicit? *If not, make them explicit.*
- Are gender roles or identities presented in absolute terms? Are stereotypes perpetuated? *If yes, acknowledge gender roles and identities as socially important and historically grown, but make it clear that they are neither necessary, natural or normatively desirable.*
- When both sexes are included, is equal attention given to female and male responses? *If no, create the appropriate balance.*

Language of Research Reporting and Research Proposals

- When both sexes are mentioned together in a phrase, does one sex consistently precede the other? *If yes, alternate in some manner.*
- Are any gender-specific terms used for generic purposes? *If yes, use generic terms when referring to both sexes.*

- Are any generic terms used for gender-specific situations? *If yes, use sex-specific terms when referring to one sex.*

Visual Representations

- Are men and women appropriately represented, given their relative importance with respect to the topic under study (e.g. significance of the problem for each sex, proportion of the population of each affected by the problem)? *If no, correct the imbalance by fairly representing the excluded or under-represented sex.*
- Are females and males depicted in stereotypical ways? *If yes, eliminate the stereotypical representation and replace with a more realistic one.*
- Are men and women depicted in ways that represent their diversity (e.g. images of visible minorities, of people with disabilities, of gay and lesbian couples)? *If no, incorporate these and other facets of diversity into the images.*

6 Policy and Program Development and Gender-based Analysis

There are various models of policy and program development. This guide suggests the following six stages of policy and program development:

1. Identify and define the policy issue
2. Define goals and outcomes
3. Engage in research and consultation
4. Develop and analyze options
5. Implement and communicate policy and program
6. Evaluate policy and program

These stages are a simplified representation of policy and program development and do not necessarily capture all of the subtleties of these processes. In addition, it is assumed in this model that evaluation feeds back into policy and program development to ensure that subsequent policies and programs are evidence-based.

Overall, GBA integrated into policy and program development models should address these questions:

- Are differences in the contexts of the lives of men and women, boys and girls addressed?
- Is the diversity within subgroups of women and men, girls and boys identified and analyzed?
- Are men and women engaged in the processes in meaningful ways to assess the impacts?
- Are intended and unintended outcomes identified?
- Are other social, political and economic realities taken into account?

These questions could be used to assess any particular policy and program development model that is being used in a given situation.

It is important to remember that the decision-making environment alters what can be seen and the actions that can be taken. The processes that lead to the actions and initiatives of policy and program development within this environment are dynamic and recur over time.

1. Identify and Define the Policy Issue

The policy agenda is determined by a complex interplay of ideas and values that can be emotionally and ideologically laden (Stone, 1989). Research is often the main tool to detect current issues, problems and challenges in the field of health. Equally important are events such as elections, disasters, critical current events and legal decisions. Many players are involved in setting the agenda—government institutions, individuals (politicians, bureaucrats, academics, researchers, think tanks), interests groups and the media.

Questions to ask:

- Is the issue or problem properly defined?
- Is it a health issue? If yes, how will the issue be situated in the population health approach?
- Is it under federal/provincial/territorial jurisdiction?
- Who has defined the issue and why?
- What evidence has been marshalled to support this framing of the issue?

- Has the issue been portrayed comprehensively to reflect the needs of women and men, girls and boys?
- What are the values, biases, knowledge and experiences at play in the framing of this issue?
- Does this issue require policy analysis/development/further research?

2. Define Goals and Outcomes

Once the issue or problem is thoroughly understood, the next stage is to identify possible responses to it and to articulate these as goals and outcomes.

- What are the stated goals of government in terms of the policy?
- What are the expected health outcomes from the policy?
- What will the activities be?
- What are the indicators of success?
- Who is the policy/program intended to benefit?
- What attempts have been made to remedy the issue or problem in the past? What were some of the outcomes of these attempts? In what ways were these outcomes different for men and women, boys and girls?
- What is the current proposal to solve the problem? What assumptions are built into the policy (e.g. established priorities and processes of department or division)?
- How does the issue or problem affect men and women (and boys and girls) and different groups of women and men (and girls and boys) differently (e.g. do the objectives of the policy or program make assumptions about the social roles of both sexes)?
- How can the equity interests of different groups be reconciled?
- Do you need additional information to do a full analysis of a policy or program?
- If yes, how will you obtain this information? Possible sources include a literature search, the media, public opinion data, non-governmental organizations, interest groups/advocacy groups/community organizations, policy documents/speeches from the throne, federal government research committees, research organizations, academics, Statistics Canada, Health Canada, Canadian Institute for Health Information, etc.

Using the widest array of evidence is important in developing solid programs and effective policies.

3. Engage in Research and Consultation

Using the widest array of evidence is important in developing solid programs and effective policies. Comprehensive evidence gathering includes both men and women in the process of defining what needs to be researched, what is missing in evidence gathered to date, and how to interpret data. Both quantitative and qualitative data are required. Qualitative research complements and enlivens quantitative data, broadens the base for decision making and sharpens the picture we are able to take of the health of the Canadian population.

*(**Note:** As a vital and central part of GBA, research is discussed in greater detail in Section 5.)*

Sources to Consult about GBA

Consultation with knowledgeable and informed sources is also an important part of the research, policy and program development process. Sources that you can consult include Health Canada's Women's Health Bureau, women's health organizations and a wide variety of governmental and non-governmental organizations working in the field of health, including those listed in the "Selected Resources for Gender-based Analysis" section of this guide.

Effective and meaningful consultation and involvement outside of government is essential to enable Health Canada to fulfil its legislative mandate, deliver programs, launch new initiatives and build public trust. As noted by the Office of Consumer and Public Involvement at Health Canada, individuals and organizations become involved in public policy decisions in a variety of capacities. There is a growing range of approaches to support meaningful participation: from a limited role in decision making to broader participation, and from traditional public consultations to open-ended models of public involvement. Therefore, involvement strategies must be designed deliberately, and in collaboration with participants, taking into account the nature of the issue, the people who are interested in and affected by decisions and the rationale for public involvement in decision making (Health Canada, 2000d).

4. Develop and Analyze Options

This stage includes making realistic, evidence-based recommendations that are congruent with the current policy environment and government objectives. Options should be assessed for their potentially adverse effects and differential impact on women and men and diverse groups of women and men, girls and boys. Future directions and research needs (e.g. gaps in knowledge) should also be identified.

- What are the probable short- and long-term effects of the policy on men and women, boys and girls? Are both sexes treated with equal concern, respect and consideration? Is the diversity among men and women, boys and girls, being considered?
- How does your knowledge of the attitudes of decision makers affect your recommendation?
- How have other government departments responded to this issue or problem? Is there an interdepartmental strategy that can be proposed?

5. Implement and Communicate Policy and Program

This stage includes the adoption, implementation and communication of recommendations. To ensure a coordinated response, consultation with other departments and/or the creation of interdepartmental mechanisms may occur. It is critical that communication and dissemination of the policy be gender-sensitive and reflect an awareness of other social differences.

- Is timing a factor?
- How does the choice of media affect dissemination to women, men and diverse groups of both?
- How does language affect the transmission of the message?

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- Is timing a factor?
- How does the choice of media affect dissemination to women, men and diverse groups of both?
- How does language affect the transmission of the message?

- How are stakeholders involved (e.g. how are you going to include program participants in the implementation)?
- How can other departments be involved in the implementation?

6. Evaluate Policy and Program

Evaluation research is designed to judge the merits of a government policy or program. It includes the systematic collection, analysis and interpretation of information concerning the need, design, implementation and impact of public policy or a program (Hayes, 2001). Evaluation, performance monitoring and policy indicators help us to determine what is and is not working, and for whom. Evaluation reflects back upon policy and program formulation and implementation, but points forward to the next round of the decision-making cycle, returning to the agenda-setting stage.

- How will the outcome of this policy or program be evaluated (including monitoring and accountability)?
- What will the indicators be?
- How will experiential knowledge and the opinions of diverse groups of men and women, boys and girls, be drawn upon in the evaluation?
- How will the differential impacts of the policy or program on women and men, boys and girls be evaluated?
- Were goals met? Was policy administered effectively? What should come next?
- What changes should be made in the policy or program so it is more responsive to the needs of diverse groups of men and women?

7 Case Studies

The effects of gender on health are seen in the context of employment, family life, education, longevity, health care treatment —indeed, in most areas of life. Without a contextual analysis of data, distinctions in health status between women and men, girls and boys, cannot be properly defined, policies and program development cannot be properly informed, and the distinct health needs of diverse groups cannot be met.

The following four case studies illustrate how dramatically different our understanding of a health issue can be when GBA is not implemented and when it is. We will look at: (1) cardiovascular disease; (2) mental health in the specific context of developing performance indicators and measures for the mental health system; (3) research on violence; and (4) tobacco policy development.

Case Study #1

A Research Case Study: Cardiovascular Disease

Historically, considerations of sex and gender differences have not been considered in research on most diseases. This omission has had far-reaching consequences for accurate diagnosis, effective treatment and prevention of cardiovascular disease (CVD) for women.[7]

Using male norms and standards for CVD results in numerous and potentially fatal "pitfalls" in both diagnosis and treatment (Legato, 1998). Evidence-based research is required to understand and respond to the significant sex- and gender-based factors that combine to affect cardiovascular health. For example, we are learning that sex-based factors affect the presentation of symptoms of myocardial infarctions. Gender-related factors affect when women and men seek treatment as well as the responses of health practitioners to men and women presenting with cardiac symptoms (Schulman et al., 1999). The combined effects of sex and gender, in interaction with other health determinants, affect health status, health system responses and eventual health outcomes (Greaves et al., 1999).

CVD, which includes myocardial infarction, ischemic heart disease, valvular heart disease, peripheral vascular disease, arrhythmias, high blood pressure and stroke, has a history of being considered a men's disease. It is only very recently that CVD has been recognized as the major cause of death in Canada for women as well as men (Heart and Stroke Foundation of Canada, 1999). One result is that women are greatly under-represented in medical research related to cardiovascular disease (Heart and Stroke Foundation of Canada, 1997; Beery, 1995).

For example:

- Women were excluded from a large study of aspirin as the primary preventative for cardiovascular death in men (Steering

[7] CVD is a critical issue to be addressed in Canadian society. In 1993, the direct costs of CVD (e.g. hospitals, physicians and drugs) were $7.27 billion. Indirect costs (e.g. costs related to mortality, long-term and short-term disability) were $12.7 billion. CVD is the largest cost category among all diagnostic categories in Canada (Moore et al., 1997).

Committee of the Physicians' Health Study Research Group, 1989). Subsequent to this research, women and men were treated with aspirin for CVD. Data have since shown that aspirin is effective for this indication in men but not women (Hamilton, 1992; McAnally, Corn and Hamilton, 1992).

- A 1992 study in the *Journal of the American Medical Association* found that women are excluded from 80% of the trials for myocardial infarction (Gurwitz, Col and Avorn, 1992). The authors concluded that findings from the trials could not be generalized to the patient population that experiences the most morbidity and mortality from acute myocardial infarction—namely, women.

- Doses of drugs given to women with heart disease are often based on studies of primarily middle-aged men even though the hormonal status, average older age and smaller body mass of women may affect drug concentrations, effectiveness, side effects and toxicity (Heart and Stroke Foundation of Canada, 1997).

From the current state of research, we have begun to identify some of the ways that sex/gender differences are relevant to risk factors, symptoms and patterns of CVD, and the implications these differences have for diagnosis and interventions, including prevention for men and women. As well, there are many lessons to be learned from CVD-related research in the past to ensure better health outcomes for women in the future.

Some Examples of Sex and Gender Differences in CVD

Risk Factors

- **Age:** Acute myocardial infarction and ischemic heart disease become important health problems starting at age 45 for men and 55 for women. Congestive heart failure and stroke affect older individuals with much higher hospital admission rates over age 75 for both women and men. (Heart and Stroke Foundation, 1999).

- **Hypertension:** High blood pressure is a major risk factor in cardiovascular disease and is two to three times more common in women than in men (Society for Women's Health Research, 1999).

- **Cholesterol levels:** High levels of the "bad" LDL (low-density lipoprotein) cholesterol are a risk factor for CVD for men. Low levels of the "good" HDL (high-density lipoprotein) cholesterol may be a bigger risk factor for women (LaRosa, 1992; 2002).

- **Diabetes:** Diabetes represents a greater risk factor in CVD for women than for men (Laurence and Weinhouse, 1997; Canadian Women's Health Network, 2001). The higher prevalence of diabetes in Aboriginal women than in Aboriginal men compounds their risk of CVD.

- **Smoking:** For women aged 50 or under who smoke, the risk of dying from a heart attack is three times greater than that of an ex-smoker. For women smokers aged 35 or older and taking oral contraceptives, the risk is higher still (Canadian Women's Health Network, 2001). We know that the

Advancing CVD Research and Knowledge

Through the Heart Health Initiative, Health Canada works closely with provincial departments of health and more than 1,000 organizations in the public, private and voluntary sectors to support an integrated approach to reduce and prevent deaths and illness due to CVD. The First International Conference on Women, Heart Disease and Stroke, funded by Health Canada, was held in Victoria, British Columbia in May 2000 to increase awareness of the problem of heart disease and stroke in women. The conference highlighted current scientific advances, gaps in knowledge and research opportunities for CVD in women. The 2000 Victoria Declaration on Women, Heart Diseases and Stroke was released at the conference.[8]

toxicants in tobacco affect many of women's biological systems differently from men's, but not enough research has focused on the sex and gender specific impacts of tobacco on CVD. The increase in rates of smoking among young girls between 1994 and 1997, (30%) compared to 17% among young boys, is a cause for concern (Heart and Stroke Foundation of Canada, 1999).

- **Inactivity:** More women than men are physically inactive in the 15- to 24-year-old age group and in the over 65 age groups (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999; Heart and Stroke Foundation of Canada, 1999).
- **Weight and Body Size:** An increase in body fat, especially intra-abdominal fat, is associated with adverse blood cholesterol levels, a higher incidence of CVD, insulin resistance and breast cancer (Naimark, Ready and Lee, 2000). The risk of heart attack is three times higher in women who are overweight than in those who have a "healthy weight" (Canadian Women's Health Network, 2001). Sex and gender differences in relation to weight and body size need further research.
- **Ethnicity:** Ethnicity and gender are important factors in CVD. For example, Aboriginal women experience higher death rates than the general Canadian female population for both ischemic heart disease and stroke (Heart and Stroke Foundation of Canada, 1999). There are also gender differences in CVD among South Asian and Black populations (Heart and Stroke Foundation of Canada, 1997).
- **Socio-economic Status and Stressors:** Poor education, lower income, family responsibilities and impoverished social connections uniquely predispose women to disease and slow recovery (Eaker, Pinsky and Castelli, 1992). Much more research is needed on how exposure to particular stressors, over the life cycle, affects CVD differently for women and men.

[8] Not yet officially ratified, the 56-page declaration asks that five values—health as a fundamental human right, equity, solidarity in action, participation and accountability—be adopted by scientists, health advocacy groups, government agencies, the media and others to serve as the foundation for the development, implementation and evaluation of all policies, programs and services earmarked for improving women's heart health. See http://www.cwhn.ca/resources/victoria_declaration/

Symptoms and Patterns of Disease

- The onset of heart disease typically develops up to 10 years later in women's lives than in men's (Heart and Stroke Foundation of Canada, 1999).
- Some women have symptoms that are different from those typically experienced by men. For example, chest pain is the most common symptom of heart attack for both women and men. However, studies show that women are more likely to have subtle symptoms of heart attack, such as indigestion, abdominal or mid-back pain, nausea and vomiting. More research is needed to explore the reasons for these differences and their clinical implications (Society for Women's Health Research, 2003; Doyal, 1998).
- Since it is still not well known that heart disease is the number one killer of women (Anderson, 2002), many women may be ignoring the symptoms of heart disease and waiting too long to seek medical help. This is compounded by physicians who do not take the symptoms women present as serious. As a result, CVD in women is often dismissed or overlooked (Laurence and Weinhouse, 1997).

Diagnosis and Interventions

- Few of the screening and diagnostic tests available for heart disease (e.g. electrocardiograms, exercise stress tests) have been specifically tested on women, thus their efficacy is unknown (Collins, Bussell and Wenzel, 1996).
- Some research suggests that women are not diagnosed and treated as aggressively as men for CVD (Khan et al., 1990 in Laurence and Weinhouse, 1997, 85–110) For example, in one study, women were less likely than men to have invasive procedures such as coronary angiography, coronary angioplasty or coronary artery bypass surgery (Maynard et al., 1992).
- During the past decade, heart attack survival has improved due to thrombolytics (clot-buster medicine) like TPA and streptokinase. However, these drugs appear to be given to women less often than men. Large studies have also found that women's survival improves with these drugs, but not to the same extent as men's, though the reason is unknown (Women's Heart Foundation,1999/2000).
- In all age groups, hospitalization rates for ischemic heart disease are much higher among men than women. The reasons for this are unclear (Heart and Stroke Foundation of Canada, 1999).
- Women tend to have longer periods of hospitalization for CVD-related illnesses. The average length of stay for women is 13.1 days compared to 11.4 days for men (Heart and Stroke Foundation of Canada, 1999).
- The majority (80%–90%) of heart transplant recipients are male (Young, 2000). More research is needed as to the causes.

Outcomes of CVD: Some Sex and Gender Differences

- During the first six months after an initial heart attack, 31% of women and 23% of men have a second heart attack (Society for the Advancement of Women's Health, 1997).
- Women fare less well than men following myocardial infarction, coronary artery bypass graft surgery and coronary

angioplasty (Women's Heart Foundation, 1999/2000; American Heart Association, 2002).

- The number of CVD-related deaths among women will likely surpass CVD-related deaths among men in the near future. This is because women tend to live longer than men and there are high CVD rates among older people (Heart and Stroke Foundation of Canada, 1999).

Recommendations

At a minimum, what is needed:

- CVD health promotion and disease prevention programs that take into account the differences in social roles between women and men. This includes programs that address different barriers to smoking cessation, physical activity and healthy nutrition encountered by women and men.
- More research on the underlying pathophysiology of heart disease and stroke and how these differ for men and women. Research is also needed on the effectiveness of prevention interventions. This will enhance the evidence base for the development of programs and services (Heart and Stroke Foundation of Canada, 1997).
- More research to investigate how other social determinants of health (e.g. income and poverty, culture and racism) have an impact on the development of CVD over a person's life cycle and how these determinants can be addressed to improve health outcomes for women and men.

This CVD case study illustrates the need to integrate an understanding of sex and gender into research methods and analyses. Doing so can uncover and eliminate gender bias in all stages of the research process, for example, when:

- formulating the research question
- assessing the literature reviewed
- designing the research methods
- gathering, analysing and interpreting data
- writing about research, by ensuring use of appropriate language, and
- presenting non-stereotypical illustrations or other visual images to communicate research

Some Lessons from Research on Women

For many years, women have been prescribed combined (estrogen and progestin) Hormone Replace Therapy (HRT) to relieve some symptoms of menopause, such as hot flashes. Earlier studies suggested that the use of HRT products might help to prevent heart disease in post-menopausal women. However, randomized clinical trials conducted as part of the Women's Health Initiative in the U.S. were terminated in July 2002 after demonstrating that hormone therapy carries greater risks than benefits and should not be prescribed to women for prevention of heart attack, stroke or any other CVD disorder. In fact, HRT increases the risk of CVD, including stroke.

Widespread prescription of HRT products to millions of women proceeded before clinical trials provided clear evidence of long-term safety and effectiveness in relation to CVD. This example reinforces the need for precaution in moving from limited research results to broad practice in large populations of women (Health Canada, 2002; National Institutes of Health, 2003).

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Case Study #2

Developing Performance Indicators and Measures for the Mental Health System

Even when research has shown significant sex and gender differences in a health area, and this knowledge has been integrated into policy statements, it may still not be reflected in the tools that are designed to monitor and assess the performance of the health system.

With regard to mental health, we know that women more often than men are diagnosed with affective disorders, personality disorders and post-traumatic stress disorder (World Health Organization, 2000). Even when women and men receive the same diagnoses (e.g. the rates of schizophrenia and bipolar disorder are the same for men and women), the onset and course of the illness may differ (Seeman, 1983). The onset of schizophrenia is earlier in men and, for reasons that are not fully understood, the course and outcome of the disease are typically worse for men than for women.

Mental health care treatment and access to services are different for different groups of consumers. For example, men predominate in long-term psychiatric institutions while women are more likely to use outpatient services (Rhodes and Goering, 1994). Social and economic marginalization also affect mental health (World Health Organization, 2001). Populations with high rates of poverty and communities that experience racism or other forms of social ostracism (e.g. homophobia and ageism) are particularly at risk for mental health problems (Boyer, Ku and Shakir, 1997). Women from these groups are especially vulnerable to health problems because of gender discrimination (Boyer, Ku and Shakir, 1997). Although some mental health plans and policy documents across Canada (e.g. Ministry of Health, the 1998 British Columbia Mental Health Plan) have begun to acknowledge the unique mental health experiences and needs of different groups of men and women, it has not translated into the use of GBA tools in mental health planning or in a commitment to gather data disaggregated by sex and other variables (e.g. race, ethnicity, socio-economic status).

A clear example of this is evident if we examine a sample performance monitoring tool.[9] If we look at Framework A (see page 26), it is apparent that knowledge about sex and gender and other diversity variables that have an impact on mental health are *not* applied in the performance indicators.

Sex disaggregation of data, while not always reported, is generally available to policy makers, as are breakdowns by age, because the data are collected. But other data on diversity variables such as race, ethnicity and sexual orientation are not usually collected. Policy makers and program developers need to think of ways to collect information that can tell us more about the interaction and meanings of mental illness, race, ethnicity, culture and sexual orientation, among other factors. Currently, such data collection raises ethical concerns that need to be carefully considered.

Three of the domains, indicators and measures adapted from a typical provincial performance monitoring tool, are described in Framework A without GBA. Framework B (see page 27) follows with GBA incorporated into the same monitoring tool.

[9] The tool presented in this example is adapted from a typical provincial performance monitoring tool.

Framework A: A Performance Monitoring Tool for Mental Health *Without* Gender-based Analysis

DOMAINE	INDICATOR	MEASURES
Access/Responsiveness	Service access	– number and percent of persons with serious illness (SMI) receiving one insured treatment service per annum – percent of persons with SMI receiving community mental health services
Quality/Appropriateness	Emergency psychiatry re-admission rates	– rate of acute care re-admissions within 30, 60, 90 days of discharge – rate of emergency presentations, within 30, 60, 90 days of discharge
Outcomes (Population & Consumer)	Mortality ratios	– mortality rates for persons receiving an insured health benefit for schizophrenia and bipolar disorder

If Framework A were used to assess the way the system is functioning, important sex and gender differences might be obscured or missed altogether. For example, research has shown that the diagnoses of borderline personality disorder (BPD) and disassociative identity disorder (DID) are more often given to women; both of these diagnoses are associated with extreme childhood sexual abuse and trauma (O'Donohue and Greer, 1992). Research suggests that this population has difficulty accessing adequate services, and providers indicate that these women repeatedly use emergency services (Morrow and Chappell, 1999). One Canadian study that followed 15 women diagnosed with Multiple Personality Disorder (the older term for DID) found that these women often go undiagnosed for over eight years (Ross and Dua, 1993). The costs to the health system are enormous: the authors estimate that savings of almost $85,000 per person could be achieved if earlier and accurate diagnosis were to occur.

Framework B corrects for this problem of missed and delayed diagnosis by capturing data on rates of acute care re-admissions by sex and diagnosis. Although it may not correct entirely for misdiagnoses, if Framework B were used it would be evident that women with severe abuse and trauma histories have a high rate of re-admissions.

Additionally, by including sex, gender, diagnoses and diversity (e.g. race, age, ethnicity, gender identity, ability) as variables, more data are gathered that may help identify how the system is functioning differently (or the same) for diverse groups of men and women.

Framework B: A Performance Monitoring Tool for Mental Health *With* Gender-based Analysis

DOMAINE	INDICATOR	MEASURES (note that sex disaggregated data may be not be available in each case)
Access/Responsiveness	Service access by sex and other diversity variables	– number and percent of men and women with serious mental illness (SMI) receiving one insured treatment service per annum – type of service accessed by men and women by age, ethnicity, sexual orientation, etc. – percent of men and women with SMI receiving community mental health services – survey of women's service organizations to find out the ways in which they are supporting women with SMI and to find out their capacity to do this effectively – survey of ethnic-specific and settlement organizations supporting people with SMI – survey of gay, lesbian, bisexual and transgender organizations supporting people with SMI
Quality/Appropriateness	Emergency psychiatry re-admission rates by sex, diagnosis and other diversity variables	– rate of acute care re-admissions by sex and diagnosis within 30, 60, 90 days of discharge – rate of emergency presentations by sex and diagnosis within 30, 60, 90 days of discharge
	Diverse male and female consumer perception of service appropriateness	– satisfaction surveys, key informant interviews, focus groups
	The perception of service appropriateness by immigrant populations and ethnic minorities	
Outcomes (Population & Consumer)	Mortality ratios by sex and other diversity variables	– mortality rates for men and women receiving an insured health benefit for schizophrenia and bipolar disorder

Framework A: A Performance Monitoring Tool for Mental Health *Without* Gender-based Analysis

DOMAINE	INDICATOR	MEASURES
Access/Responsiveness	Service access	– number and percent of persons with serious illness (SMI) receiving one insured treatment service per annum – percent of persons with SMI receiving community mental health services
Quality/Appropriateness	Emergency psychiatry re-admission rates	– rate of acute care re-admissions within 30, 60, 90 days of discharge – rate of emergency presentations, within 30, 60, 90 days of discharge
Outcomes (Population & Consumer)	Mortality ratios	– mortality rates for persons receiving an insured health benefit for schizophrenia and bipolar disorder

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Framework B: A Performance Monitoring Tool for Mental Health *With* Gender-based Analysis

DOMAINE	INDICATOR	MEASURES (note that sex disaggregated data may be not be available in each case)
Access/Responsiveness	Service access by sex and other diversity variables	– number and percent of men and women with serious mental illness (SMI) receiving one insured treatment service per annum – type of service accessed by men and women by age, ethnicity, sexual orientation, etc. – percent of men and women with SMI receiving community mental health services – survey of women's service organizations to find out the ways in which they are supporting women with SMI and to find out their capacity to do this effectively – survey of ethnic-specific and settlement organizations supporting people with SMI – survey of gay, lesbian, bisexual and transgender organizations supporting people with SMI
Quality/Appropriateness	Emergency psychiatry re-admission rates by sex, diagnosis and other diversity variables	– rate of acute care re-admissions by sex and diagnosis within 30, 60, 90 days of discharge – rate of emergency presentations by sex and diagnosis within 30, 60, 90 days of discharge
	Diverse male and female consumer perception of service appropriateness The perception of service appropriateness by immigrant populations and ethnic minorities	– satisfaction surveys, key informant interviews, focus groups
Outcomes (Population & Consumer)	Mortality ratios by sex and other diversity variables	– mortality rates for men and women receiving an insured health benefit for schizophrenia and bipolar disorder

Case Study #3

Understanding Research on Violence[10]

The following is an excerpt from the conclusion of a chapter on violence from a publication of the Finnish Office of Statistics (Heiskanen et al., 1991). Version A is Heiskanen et al.'s original. Version B has been rewritten (by Margrit Eichler in Health Canada, 2000c) after conducting a gender-based analysis using only the information found within the original chapter itself.

A: Original Version

About one person out of ten was the victim of a violent act or threats of violence during 1980, and one person out of twelve was a victim in 1988. Almost half (46%) of the victims had at least two such experiences in 1980; in 1988, the proportion of such victims was 45%. The victim was most likely a single young man.

The relative number of persons who were victims of incidents that resulted in restricted activity has also fallen, but only slightly.

The decrease in the number of experiences of violence from 1980 to 1988 was most accentuated among the youngest men, and in the category of street violence. An exception from the overall decreasing trend was work-related violence experiences, which have become more numerous. In 1988, family violence remained rather close to the numbers measured in 1980.

Work-related violence has become more common among women in the most active age of participation in the labour force (ages 20–44). Among men, the number of such experiences has simultaneously fallen.

B: A Gender-based Analysis of the Information Provided

The most obvious observation when looking over the statistics on violence is the degree to which this is a gendered experience. While men are slightly more likely to be victims of violence than women, this difference has decreased between 1980 and 1988. In 1980, 58% of all victims were men and 42% were women; in 1988, 53% were men and 47% were women. The typical male victim experienced the violence on the street; the typical female victim suffered violence from a family member in her own home.

The starkest indication of gender differences in this area concern the gravity of the consequences: while the number and the proportion of male victims who suffered incidences which resulted in at least one day of restricted activity fell from 12,440 or 3.4% of all victims to 7,146 or 2.7% between 1980 and 1988, female victims experienced just the opposite trend. The number of women who experienced restricted activity following an incidence of violence increased both in absolute number, as well as relatively, from 9,533 or 3.6% of all female victims in 1980 to 11,974 or 5.1% in 1988. Not only have women become more likely to be victims of violence than they were in 1980, their

[10] This case study is adapted from Dr. Margrit Eichler, "Moving Toward Equality: Improving the Health of All People: Recognizing and Eliminating Gender Bias in Health," Health Canada (draft), Women's Health Bureau, 2000c. Permission is granted for non-commercial reproduction of this adaptation on condition that Dr. Margrit Eichler is clearly acknowledged as the author. For a fuller discussion, refer to Dr. Margrit Eichler, Feminist Methodology, *Current Sociology*, April 1997, Vol. 45(2): 9–36.

likelihood of suffering restricted activity as a consequence has almost doubled. In other words, the acts of violence have become more violent.

Both women and men experienced a relative decrease in small group violence and street violence, and an increase in family violence, work-related violence, and other violence. Although the proportion of violence that was work-related for women almost doubled, the single most important category experienced by women was family violence

What are the messages derived from the two versions?

1. Typical victim
   A. A young man
   B. Typical male victim is a victim of street violence; typical female victim is a victim of family violence

2. Likelihood of restricted activity of victim
   A. Slightly decreased
   B. Decreased for men, but increased for women

3. Likelihood to experience violence in 1988, relative to 1980
   A. Young men less likely
   B. Fewer incidents of violence experienced by both sexes, but the proportion of victims who were female increased

4. Work-related violence
   A. Increased
   B. Decreased for men, but increased for women

5. Family violence
   A. Remained stable
   B. Proportionately increased for both sexes, but remains a tiny proportion of violence experienced by men (2.3%); single largest type of violence experienced by women (27.5%)

Is the second version free of gender bias?

No. It is less biased than the first, but it cannot overcome the problems that are inherent in either the design or the data manipulation that is failing to ask for the sex of the perpetrator. To avoid bias, perpetrators need to be held responsible for their action. The most glaring omission in the chapter under consideration is that there are only victims, and no perpetrators, or when they do appear, they are sexless.

One table in the study identifies the relationship between the victim and the perpetrator. The categories are: stranger, known by sight or name only, closer acquaintance, relative, spouse, other family member, other member of household, other person, and no data.

Neither the victim nor the perpetrator is identified, so there is no way of knowing what sex they are. This is an incidence of gender insensitivity that cannot be overcome by re-analysing the data provided. The table would look quite different if the sex of perpetrator and victim were specified by simply identifying the sex within each of the current categories of perpetrators. Having these data would alter our appreciation of the other data very significantly. Had we had this

information, our summary would read significantly differently. Nevertheless, even sticking with the data presented, a partial remediation of gender insensitivity results in dramatically different conclusions from those in the original version.

Does avoiding gender bias guarantee that policies, programs and research will be good?

No. They may have a host of other problems, be poorly designed (as in B), ask an irrelevant question, fail to report methods fully, be unrelated to a departmental policy, draw inappropriate conclusion, and so on.

Therefore, analysing and developing policies, developing and implementing programs and conducting qualitative and quantitative research that are free of gender bias are necessary, but not sufficient conditions for good policy, programs and research. Other principles of conducting good policies, programs and research continue to apply.

Case Study #4
Tobacco Policy

Tobacco use in Canada is on the decline, yet it remains the number one preventable cause of death and disease. One out of two smokers will eventually die from smoking-related causes (World Health Organization, 1999). In the face of this, there are sex- and gender-related issues and trends that deserve closer attention.

The male smoking rate in Canada has declined much faster over the past few decades than the female smoking rate (Health Canada, 1999a; 2000a; 2001c). More recently and for the first time in history, the rate of young women's smoking has surpassed that of young men. The consumption rates of young female smokers are on the rise, meaning more cigarettes per day are being smoked than before (Health Canada, 1999a; 2000a; 2001c).

In recent years, Canada has taken a gendered approach to the examination of tobacco use. For example, in 1987 the *Background Paper on Women and Tobacco* provided a comprehensive analysis of the issue (Greaves, 1990). It focused on knowledge about women and tobacco use and trends that were apparently different among female and male smokers. In 2000, *Filtered Policy: Women and Tobacco in Canada* undertook a GBA of tobacco policy, urging full consideration of the gendered nature of life, identifying income adequacy, child care responsibility and the nature of women's work as key features of women's lives (Greaves and Barr, 2000).

Increasingly, tobacco cessation programs in Canada have moved away from a focus on the general adult population to specific segments of the population. These programs focus on the role that life circumstances play in the choices that people make to continue or quit smoking.[11] Women have been identified as a high-priority group and a

[11] For example, see Health Canada's *Quit for Life* website, http://www.quit4life.com/

number of community-based programs and resource materials have been developed specifically for them.[12] For example, one approach has been to target program development and research on tobacco use to a range of subgroups of women and a range of specific life circumstances. These include adolescents, Aboriginal females, Francophone women, women with low literacy, and pregnant smokers.

Without GBA, tobacco policy tends to be constructed to affect the entire population. Knowledge about how this policy may differentially affect women and men or various subgroups of each is not considered.

Cigarette price increases, for example, have differential effects on low-income and high-income Canadians, younger and older smokers and men and women. It is important to consider trends in tobacco use and the different social and economic roles that women and men play in order to understand and anticipate these effects.

Tobacco control and tobacco cessation are key policy areas in which the implementation of GBA is critical. Version A below considers each policy area *without* the use of the sex and gender filter and other features of GBA. Version B applies them.

Version A:	Version B:
Tobacco Taxation and Pricing *Without* Gender-based Analysis Taxation policies do not calculate or ameliorate specific effects on low-income people. Nor do they investigate the unintended and possibly negative consequences—such as spending less money on food—when household expenditure on tobacco is increased.	**Tobacco Taxation and Pricing *With* Gender-based Analysis** The effects of increased taxation and higher prices are investigated to reveal their consequences for low-income men and women. Household expenditure patterns, particularly with regard to food, are considered. Measures are taken to ameliorate these effects by, for example, providing free cessation aids or programs and/or nutritional supplements.

[12] For example, http://www.hc-sc.gc.ca/hecs-sesc/tobacco/pdf/women_en.pdf and http://www.hc-sc.gc.ca/hecs-sesc/tobacco/prof/women/getting_smoke_free/toc.html

Version A:	Version B:
Health Warnings and Packaging Strategies *Without* Gender-based Analysis Direct and dramatic messages about damage during pregnancy or damage to children do not convey concern about women's health. Improving a woman's own health is not the stated objective. Instead, these messages suggest that pregnant women are regarded primarily as reproducers.	**Health Warnings and Packaging Strategies *With* Gender-based Analysis** Pregnant women are recognized as wanting the best for their children and being conflicted about their smoking. Support and empathy are communicated through health warnings and information inserts about cessation or the social context of women's smoking.
Version A:	**Version B:**
Reducing Environmental Tobacco Smoke *Without* Gender-based Analysis No recognition or analysis is made of the gendered nature of child care and the added impact on women of messages about reducing environmental tobacco smoke (ETS) for children. The consequences of ETS reduction policies in child custody, neglect and abuse cases are not evaluated.	**Reducing Environmental Tobacco Smoke *With* Gender-based Analysis** Recognition is given to the fact that exposure to ETS is most likely to occur in disadvantaged homes where both women and children are less likely to have options to visit venues outside of the home. Efforts are made to avoid blame and work toward mutual goals of reducing children's exposure to ETS.

Ironically, in the tobacco industry, GBA has been applied to tobacco marketing since 1928 (Greaves, 1996). At that time, the industry promoted certain brands of cigarettes as "female" and created advertising campaigns reflecting this. These campaigns have continued through the decades, artfully and effectively promoting images of smoking to women that were consistent with social and political events and trends. Women were (and continue to be) targeted for market growth. This gendered analysis—where the tobacco industry looks at its market in two groups, male and female—continues to inform industry-driven research, product development and advertising. In recent years, the tobacco industry has embraced diversity and specifically targeted its advertising and product to various racial and ethnic groups as well as to gays and lesbians (Greaves, 1996). Implementation of GBA in health research, policy and program development is critical to countering these strategies.

Lessons Learned

These four case studies demonstrate the importance of applying GBA to see and understand similarities and differences based on sex and gender, as well as other forms of social difference. All four illustrate the need to both generate and integrate evidence and research that shows sex and gender differences in the reporting of research and in the development of policy and system evaluation tools. In our health system, this evidence could contribute to more accurate and informative diagnoses and treatment, and performance indicators and measures. In the reporting of research on violence, it could illuminate important differences that are otherwise lost. Though routinely taken into account by tobacco advertising agencies, knowledge about sex and gender has, until very recently, been ignored in research and policy development on smoking cessation, tobacco taxation and environmental tobacco smoke. Finally, all four cases suggest that more research is needed that focuses on the intersections between sex, gender and other health determinants.

Ironically, in the tobacco industry, GBA has been applied to tobacco marketing since 1928.

8 Conclusion

Governments and organizations throughout the world are adopting GBA strategies. Within Health Canada, the implementation and use of GBA will lead to more accurate pictures of health and disease. Better science will be generated by more rigorous methods that will produce more valid results: "Good science makes for good policy. Together they lead to better health for all Canadians" (Health Canada, 2000b). This better evidence base will generate more targeted policies, effective programs, appropriate interventions and accurate evaluations. Ultimately, GBA should lead to improvements in preventive, diagnostic and therapeutic practices and have a positive impact on health outcomes and the quality of health care for men and women, boys and girls in Canada.

> *"Good science makes for good policy. Together they lead to better health for all Canadians."*

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11 Selected Resources for Gender-based Analysis

National Health Resources

Canadian Health Network
http://www.canadian-health-network.ca/

Canadian Institute for Health Information
http://www.cihi.ca/
377 Dalhousie Street, Suite 200
Ottawa (Ontario) K1N 9N8
Telephone: (613) 241-7860
Fax: (613) 241-8120

Canadian Institutes of Health Research
http://www.cihr-irsc.gc.ca
410 Laurier Avenue West, 9th floor
Address Locator 4209A
Ottawa (Ontario) K1A 0W9
Telephone: (613) 941-2672
Fax: (613) 954-1800
E-mail: info@cihr-irsc.gc.ca

CIHR Institute of Gender and Health
http://www.cihr-irsc.gc.ca/institutes/igh/index_e.shtml
University of Alberta
700 UEC, 8303–112th Street
Edmonton (Alberta) T6G 2T4
Telephone: (780) 492-6699
Fax: (780) 492-3689

Health Canada
http://www.hc-sc.gc.ca
Headquarters
A.L. 0900C2
Ottawa (Ontario) K1A 0K9
Telephone: (613) 957-2991
Fax: (613) 941-5366
TTY: 1-800-267-1245
E-mail: info@hc-sc.gc.ca

Women's Health Bureau
http://www.hc-sc.gc.ca/english/women/
Health Canada
3rd floor, Jeanne Mance Building
Tunney's Pasture
Postal Locator 1903C
Ottawa (Ontario) K1A 0K9
Telephone: (613) 957-2721
Fax: (613) 952-3496
E-mail: women_femmes@hc-sc.gc.ca

Women's Health Contribution Program
http://www.cewh-cesf.ca
Women's Health Bureau
Health Canada
3rd floor, Jeanne Mance Building
Tunney's Pasture
Postal Locator 1903C
Ottawa (Ontario) K1A 0K9
Fax: (613) 941-8592
E-mail: cewhp@hc-sc.gc.ca

The **Women's Health Contribution Program**, *managed by the Women's Health Bureau, Health Canada, supports four Centres of Excellence for Women's Health, the Canadian Women's Health Network and other initiatives, including working groups that address emerging women's health issues:*

BC Centre of Excellence for Women's Health
http://www.bccewh.bc.ca/
E311–4500 Oak Street
Vancouver (British Columbia) V6H 3N1
Telephone: (604) 875-2633
Fax: (604) 875-3716
E-mail: bccewh@cw.bc.ca

Prairie Women's Health Centre of Excellence
http://www.pwhce.ca
Administrative Centre
56 The Promenade
Winnipeg (Manitoba) R3B 3H9
Telephone: (204) 982-6630
Fax: (204) 982-6637
E-mail: pwhce@uwinnipeg.ca

National Network on Environments and Women's Health
http://www.yorku.ca/nnewh/english/nnewhind.html
c/o Centre for Health Studies
York University
4700 Keele Street
214 York Lanes
Toronto (Ontario) M3J 1P3
Telephone: (416) 736-5941
Fax: (416) 736-5986
E-mail: nnewh@yorku.ca

Atlantic Centre of Excellence for Women's Health
http://www.medicine.dal.ca/acewh/
5940 South Street, Room 402
PO Box 3070
Halifax (Nova Scotia) B3J 3G9
Telephone: (902) 470-6725
Toll free: 1-888-658-1112
Fax: (902) 470-6752
E-mail: ACEWH@dal.ca

Canadian Women's Health Network
http://www.cwhn.ca
419 Graham Avenue, Suite 203
Winnipeg (Manitoba) R3C 0M3
Telephone: (204) 942-5500
Fax: (204) 989-2355
E-mail: cwhn@cwhn.ca
Clearinghouse: 1-888-818-9172

National Coordinating Group on Health Care Reform and Women
http://www.cewh-cesf.ca/healthreform/index.html

Women and Health Protection
http://www.whp-apsf.ca/en/index.html

Rural and Remote Women's Health
http://www.cewh-cesf.ca/en/resources/rural_remote/index.html

Biotechnology and Women's Health
http://www.cwhn.ca/groups/biotech/

Federal Gender Equality Resources

Agriculture and Agri-Food Canada
http://www.rural.gc.ca/cris/directories/women_e.phtml
Farm Women's Bureau
Sir John Carling Building, 3rd floor
930 Carling Avenue
Ottawa (Ontario) K1A 0C5
Toll free: 1-800-554-5630
Fax: (613) 759-7131
E-mail: fwb@agr.gc.ca

Canadian International Development Agency
http://www.acdi-cida.gc.ca/equality
Gender Equality Division
200, Promenade du Portage, 12th floor
Gatineau (Quebec) K1A 0G4
Fax: (819) 953-6356
E-mail: info@acdi-cida.gc.ca

Citizenship and Immigration Canada
http://cicnet.ci.gc.ca/english/irpa/c11-gender.html
Manager, Gender-based Analysis Unit
365 Laurier Avenue West
Jean Edmonds Tower South, 18th Floor
Ottawa (Ontario) K1A 1L1
Telephone: (613) 954-8797
Fax: (613) 957-5913

Foreign Affairs and International Trade
http://www.dfait-maeci.gc.ca/foreign_policy/human-rights/women-en.asp
Human Rights, Humanitarian Assistance and International Women's Equality Division (AGH)
Lester B. Pearson Building
125 Sussex Drive
Ottawa (Ontario) K1A 0G2
Telephone: (613) 944-2152
Fax: (613) 943-0606

Health Canada
Women's Health Bureau
http://www.hc-sc.gc.ca/english/women/
3rd floor, Jeanne Mance Building
Tunney's Pasture
Postal Locator 1903C
Ottawa (Ontario) K1A 0K9
Telephone: (613) 957-2721
Fax: (613) 952-3496
E-mail: women_femmes@hc-sc.gc.ca

Human Resources Development Canada
http://www.hrdc-drhc.gc.ca/sp-ps/gap-pas/home.shtml
Gender Analysis and Policy Directorate
140, Promenade du Portage, Phase IV
3rd floor
Gatineau (Quebec) K1A 0J9
Telephone (publications): (819) 997-9251

Indian and Northern Affairs Canada
http://www.ainc-inac.gc.ca/pr/pub/eql/index_e.html
Women's Issues and Gender Equality Directorate
Les Terrasses de la Chaudière
10 Wellington Street, 5th Floor
Gatineau (Quebec) K1A 0H4
Telephone: (819) 953-9857
Fax: (819) 953-9987

Department of Justice Canada
http://canada.justice.gc.ca/en/dept/pub/guide/guide.htm
Diversity and Gender Equality (DAGE) Office
284 Wellington Street, East Memorial Building
Ottawa (Ontario) K1A 0H8
Telephone: (613) 954-5970
Fax: (613) 946-0925

Status of Women Canada
http://www.swc-cfc.gc.ca
Gender-based Analysis Directorate
123 Slater Street, 11th floor
Ottawa (Ontario) K1P 1H9
Telephone: (613) 995-7835
Fax: (613) 947-0530
E-mail: gbad@swc-cfc.gc.ca

Provincial/Territorial Gender Equality Resources

Alberta

Human Rights and Citizenship Commission
Government of Alberta
http://www.albertahumanrights.ab.ca
Alberta Community Development
Room 800 Standard Life Centre
10405 Jasper Avenue
Edmonton (Alberta) T5J 4R7
Telephone: (780) 427-3116 (In Alberta, but outside of Edmonton, dial 310-0000)
Fax: (780) 422-3563
TTY: (780) 427-1597

British Columbia

Ministry of Community, Aboriginal and Women's Services
Government of British Columbia
http://www.gov.bc.ca/mcaws/
Women's Policy Branch
P.O. Box 9490
Stn Prov Govt
Victoria (British Columbia) V8W 9N7
Telephone: (250) 953-4504
Fax: (250) 387-4048

Manitoba

Manitoba Women's Directorate
http://www.gov.mb.ca/wd/
100–175 Carlton Street
Winnipeg (Manitoba R3C 3H9
Telephone: (204) 945-3476
Toll free: 1-800-263-0234
Fax: (204) 945-0013
E-mail: mwd@gov.mb.ca

Manitoba Women's Advisory Council
http://www.mwac.mb.ca/
107–175 Carlton Street
Winnipeg (Manitoba) R3C 3H9
Telephone: (204) 945-6281
Toll Free: 1-800-282-8069 Ext. 6281
Fax: (204) 945-6511
E-mail: 001women@gov.mb.ca

New Brunswick

Executive Council Office – Women's Issues Branch
Government of New Brunswick
http://www.gnb.ca/0012/Womens-Issues/
670 King Street, 2nd floor
Fredericton (New Brunswick) E3B 5H1
Telephone: (506) 453-8126
Fax: (506) 453-7977

Newfoundland and Labrador

Women's Policy Office
Government of Newfoundland and Labrador
http://www.gov.nf.ca/exec/wpo/wpo.htm
P.O. Box 8700
St. John's (Newfoundland) A1B 4J6
Telephone: (709) 729-5009
Fax: (709) 729-2331
E-mail: wpo@gov.nl.ca

Women's Health Network – Newfoundland and Labrador
http://www.whnnl.mun.ca/
Grace Hospital, Nurses Residence
214 LeMarchant Road
St. John's (Newfoundland) A1E 1P9
Telephone: (709) 777-7435
Fax: (709) 777-7435
E-mail: whnmun@morgan.ucs.mun.ca

Northwest Territories

Status of Women Council N.W.T.
http://www.statusofwomen.nt.ca/
P.O. Box 1320
Yellowknife (North West Territories) X1A 2L9
Telephone: (867) 920-6177 or 1-888-234-4485
Fax: (867) 873-0285
E-mail: council@statusofwomen.nt.ca

Nova Scotia

Nova Scotia Advisory Council on the Status of Women
http://www.gov.ns.ca/staw/
P.O. Box 745
Halifax (Nova Scotia) B3J 2T3
Telephone: (902) 424-8662
Fax: (902) 424-0573
E-mail: nsacsw@gov.ns.ca

Nunavut

Minister Responsible for the Status of Women
Government of Nunavut
P.O. Box 2410
Iqaluit (Nunavut) X0A 0H0
Telephone: (867) 975-5024
Fax: (867) 975-5095

Qulliit Nunavut Status of Women Council
P.O. Box 388
Iqaluit (Nunavut) X0A 0H0
Telephone: (867) 979-6690
Fax: (867) 979-1277
Toll free 1-866-623-0346
E-mail: qulliit@nunanet.com

Ontario

Ontario Women's Directorate
http://www.gov.on.ca/mczcr/owd/index.html
Mowat Block, 6th floor
900 Bay Street
Toronto (Ontario) M7A 1L2
Telephone: (416) 314-0300
Fax: (416) 314-0247
E-mail: info@mczcr.gov.on.ca

Ontario Women's Health Council
http://www.womenshealthcouncil.com/
101 Bloor St. W., 5th Floor
Toronto (Ontario) M5S 2Z7
Telephone: (416) 327-8348
Fax: (416) 327-3200
E-mail: OWHCinfo@moh.gov.on.ca

Prince Edward Island

P.E.I. Advisory Council on the Status of Women
http://www.gov.pe.ca/acsw/
P.O. Box 2000
9 Queen Street, 1st floor
Charlottetown (Prince Edward Island)
C1A 7N8
Telephone: (902) 368-4510
Fax: (902) 368-4516
E-mail: peiacsw@isn.net

Interministerial Women's Secretariat (P.E.I.)
http://www.gov.pe.ca/pt/iws-info/index.php3
Fifth Floor, Sullivan Building
16 Fitzroy Street
P.O. Box 2000
Charlottetown (Prince Edward Island)
C1A 7N8
Telephone: (902) 368-6494
Fax: (902) 569-7798
E-mail: scbentley@gov.pe.ca

Quebec

Secrétariat à la condition féminine
Gouvernement du Québec
http://www.scf.gouv.qc.ca/index_an.asp
905, avenue Honoré-Mercier, 3e étage
Québec (Québec) G1R 5M6
Telephone: (418) 643-9052
Fax: (418) 643-4991
E-mail: cond.fem@scf.gouv.qc.ca

Conseil du statut de la femme
http://www.csf.gouv.qc.ca/
Édifice Thaïs-Lacoste-Frémont
8, rue Cook, 3e étage
Québec (Québec) G1R 5J7
Telephone: (418) 643-4326
Toll free: 1-800-463-2851
Fax: (418) 643-8926
E-mail: csf@csf.gouv.qc.ca

Réseau québécois d'action pour la santé des femmes
http://www.rqasf.qc.ca/
4273, rue Drolet, bureau 406
Montréal (Québec) H2W 2L7
Telephone: (514) 877-3189
Fax: (514) 877-0357
E-mail: rqasf@rqasf.qc.ca

Saskatchewan

Status of Women Office
http://www.swo.gov.sk.ca/
Government of Saskatchewan
3rd Floor, 1870 Albert Street
Regina (Saskatchewan) S4P 3V7
Telephone: (306) 787-7401
Fax: (306) 787-2058
E-mail: swowebmaster@lab.gov.sk.ca

Yukon

Yukon Women's Directorate
http://www.womensdirectorate.gov.yk.ca/
P.O. Box 2703
Whitehorse (Yukon) Y1A 2C6
Telephone: (867) 667-3030
Fax: (867) 393-6270
E-mail: womens.directorate@gov.yk.ca

International Health and Gender Equality Resources

The Beijing Declaration and Platform for Action
http://www.un.org/womenwatch/daw/beijing/platform/index.html

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
http://www.un.org/womenwatch/daw/cedaw/cedaw.htm

Database of Instruments for Gender Mainstreaming (DIGMA)
http://www.amazone.be/

Gender and Health Equity Project
http://www.ids.ac.uk/bridge/reports/geneqfolder.pdf

Gender and Youth Affairs Department
Commonwealth Secretariat
http://www.thecommonwealth.org/gender/
Marlborough House
Pall Mall
London SW1Y 5HX
United Kingdom
Telephone: + 44 207 747 6460/6467
Fax: +44 207 930 1647
E-mail for Division: gad@commonwealth.int
E-mail for contact person:
m.roberts@commonwealth.int

Gender in Development Programme
United Nations Development Programme
http://www.undp.org/gender/
E-mail: gidp@undp.org

International Center for Research on Women
http://www.icrw.org/
1717 Massachusetts Avenue N.W., Suite 302
Washington, DC 20036
USA
Telephone: (202) 797-0007
Fax: (202) 797-0020
E-mail: info@icrw.org

International Development Research Centre
http://www.idrc.ca/gender/
Gender and Sustainable Development Unit
c/o IDRC
P.O. Box 8500
Ottawa (Ontario) K1G 3H9
Telephone: (613) 236-6163 ext. 2209
Fax: (613) 238-7230
E-mail: gsd@idrc.ca

Oxfam
http://www.oxfam.org/eng/

Pan American Health Organization
http://www.paho.org
525 23rd Street N.W.
Washington, DC 20037
USA
Telephone: (202) 974-3000
Fax: (202) 974-3663

United Nations Division for the Advancement of Women
http://www.un.org/womenwatch/daw/
2 UN Plaza, DC2 – 12th floor
New York, NY 10017
USA
Fax: (212) 963-3463
E-mail: daw@un.org

UNICEF
http://www.unicef.org/ (search Gender)
E-mail: netmaster@unicef.org

UNIFEM
http://www.unifem.org/
United Nations Development Fund for Women
304 East 45th Street, 15th floor
New York, NY 10017
USA
Telephone: (212) 906-6400
Fax: (212) 906-6705
E-mail: unifem@undp.org

United Nations International Research and Training Institute for the Advancement of Women (UN INSTRAW)
http://www.un-instraw.org
César Nicolás Penson 102-A
Santo Domingo, República Dominicana
Telephone: +1 (809) 685 2111
Fax: +1 (809) 685 2117
E-mail: comments@un-instraw.org

Women's Health in South East Asia (South East Asia Regional Strategy for Gender Mainstreaming in Health)
http://w3.whosea.org/women2/gendermain.htm
World Health Organization
Regional Office for South East Asia
World Health House
Indraprastha Estate
Mahatama Gandhi Marg
New Delhi 110 002
India

The World Bank Gender Net
http://www.worldbank.org/gender/
E-mail: gnetwork@worldbank.org

World Health Organization
http://www.who.int/health_topics/gender/en/
Avenue Appia 20
1211 Geneva 27
Switzerland
Telephone: (+00 41 22) 791 21 11
Fax: (+00 41 22) 791 3111

Appendix 1 Important Policies and Legislative Measures

Policies

Ottawa Charter for Health Promotion (World Health Organization, 1986)
The *Ottawa Charter* states that fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

The *Ottawa Charter* states that: "Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential.... People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men."

The *Ottawa Charter* identifies a general strategy consisting of three interlocking components:

1. Intersectoral action to achieve healthy public policy as well as public health policy.
2. Affirmation of the active role of the public in using health knowledge to make choices conducive to heath and to increase control over their own health and over their environments.
3. Community action by people at the local level. Strengthening public participation and public direction of health matters is at the heart of the health promotion strategy.

Setting the Stage for the Next Century: The Federal Plan for Gender Equality (1995)
The Federal Plan is the Government of Canada's blueprint for gender equality. It is both a statement of specific commitments and a framework for the future, representing the concerted effort of 24 federal departments and agencies, spearheaded by Status of Women Canada.

In this document the federal government states its commitment "to ensure that all future legislation and policies include, where appropriate, an analysis of the potential for different impacts on women and men" (17).

The federal plan identifies the following objectives to achieve gender equality:

- Implement gender-based analysis throughout federal departments and agencies.
- Improve women's economic autonomy and well-being.
- Improve women's physical and psychological well-being.
- Reduce violence in society, particularly violence against women and children.

- Promote gender equality in all aspects of Canada's cultural life.
- Incorporate women's perspectives in governance.
- Promote and support global gender equality.
- Advance gender equality for employees of federal departments and agencies.

Health Canada's Women's Health Strategy (1999)
Health Canada identifies women's health as a priority and has developed a strategy to begin responding to women's health concerns. The Strategy states that when interpreting and enforcing the *Canada Health Act* the government will consider the particular needs of women by ensuring that gender impacts of policy interpretations or changes are fully assessed. The Strategy has four main objectives:

1. to ensure that Health Canada's policies and programs are responsive to sex and gender differences and to women's health needs;
2. to increase knowledge and understanding of women's health and women's health needs;
3. to support the provision of effective health services to women; and
4. to promote good health through preventive measures and to reduce the risk factors that most imperil the health of women.

From these four objectives flows Health Canada's commitment to gender-based analysis.

Health Canada's Gender-based Analysis Policy (2000)
Health Canada's Gender-based Analysis Policy states that "Health Canada is committed to the implementation of gender-based analysis throughout the department. This approach to developing policies, programs and legislation will help us secure the best possible health for the women and men and girls and boys of Canada."

The policy also states that GBA analysis applies to all the substantive work of Health Canada. GBA is a tool for examining and assessing the links between gender and health and between gender and other health determinants.

The policy emphasizes that GBA should intersect with a diversity analysis that considers factors such as race, ethnicity, level of ability and sexual orientation.

Legislative Measures

The *Canadian Charter of Rights and Freedoms* (1982)[13]
The *Canadian Charter of Rights and Freedoms* protects those basic rights and freedoms of all Canadians that are considered essential to preserving Canada as a free and democratic country. Three sections of the Charter (Sections 15 and 28) outline the basis for all Canadians to be treated equally.

[13] Source: http://canada.justice.gc.ca/Loireg/charte/const_en.html#egalite

Section 15 Equality Rights

1. Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
2. Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Section 15 of the Charter makes it clear that every individual in Canada—regardless of race, religion, national or ethnic origin, colour, sex, age or physical or mental disability—is to be considered equal. The Charter also allows for certain laws or programs that favour disadvantaged individuals or groups under Section 15(2). For example, programs aimed at improving employment opportunities for women, Aboriginal peoples, visible minorities, or those with mental or physical disabilities are allowed under Section 15(2).

Section 27 Multicultural Heritage

This Charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians.

Section 28 Rights Guaranteed Equally to Both Sexes

Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons.

These sections make it clear that both women and men, and diverse groups, are equally protected under the Charter.

The Canada Health Act (1984)

The *Canada Health Act* (1984) sets out the principles that constitute the framework of the Canadian health care system. According to the Act, "The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The *Canada Health Act* is based on the principles of accessibility, universality, comprehensiveness, portability and public administration.

Appendix 2 Gender-based Analysis and Social Trends

Social, economic and political conditions shape distributions of determinants of health, disease and well-being (Krieger and Zierler, 1995). While research and knowledge of past, present and emerging trends is increasing, there must be sustained efforts to monitor trends in relation to their impact on the overall health of the Canadian population (Townson, 1999). Doing so requires GBA, which views policy as inseparable from social context, existing policy or emerging trends, thus painting a picture of how these challenges can be addressed for positive progress.

The key question to ask is: Who is affected by this trend, and in what way?

Research and monitoring with a gender lens captures the impact of a trend on both women and men. When you examine the trend in the light of historical and current context, you can expect to see different effects for different groups of men and women, boys and girls. The potentially different impact of each of these trends and patterns needs to be examined and assessed in policy and program design and implementation. The key question to ask is: Who is affected by this trend, and in what way?

Aging

In 2000, there were an estimated 3.8 million Canadians aged 65 and over, an increase of 62% from 2.4 million 20 years earlier (Health Canada, 2001a).

In 2000, 57% of all people aged 65 or over and 70% of all persons aged 85 and over were women. This is a comparatively new phenomenon. Fifty years ago there were more senior men than senior women. It is estimated that the current situation will remain quite stable over the next few decades: it is projected that women in 2051 will make up 55% of the overall senior population, just slightly fewer than they do today (Health Canada, 2001b).

On average, Canadian women out live men by six years. However, disability, health problems and isolation often accompany women's final years (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

Immigration and Cultural Diversity

In 1996, immigrants made up 17.4% of the population, or one in six people (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Some of these individuals may embrace non-western conceptualizations of health and illness, favouring alternative or complementary forms of treatment (Tudiver and Hall, 1996).

Health issues of concern to some immigrant women include sexual and reproductive cancers, mental health, perceptions of wellness, caregiving, pregnancy and female genital mutilation (Kinnon, 1999).

Most new immigrants to Canada now come from non-European countries. While those from Europe still comprised the largest regional subgroup in 1996, for the first time they accounted for less than half (47%) of the total immigrant population, largely because of recent immigration from Asia (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). This means there is an increasing need to document the health consequences of racism and the impact of the settlement process on the health of new Canadians (Noh, 1999).

Family Structure

Patterns of fertility, marriage and divorce shape men and women's participation in the labour force and in their family lives. Since 1959, women have had fewer children on average and have started their families at a later age (Johnson, Lero & Rooney, 2001). Families are also changing as a result of declining marriage and increasing divorce rates. There are growing numbers of blended families, gay and lesbian partnerships, lone parents, parents living apart with joint custody arrangements, and common-law partnerships.

Labour Force Participation

Women who work full time earn 73% of what men earn for full-year, full-time work (Statistics Canada, 1998). In addition, women still perform the majority of household chores and child care (Marshall, 1993). Recent economic restructuring has increased the gap between lower paid and higher paid jobs, and the nature of work and patterns of employment are changing with more non-union labour and part-time contract employment. These trends affect the patterns of women's and men's work, with more women in less stable part-time positions.

Poverty

One in five women is living in poverty (2.8 million) and their poverty is closely linked to that of children (Statistics Canada, 2000). Poor health is also linked to low income (National Forum on Health, 1997). Elderly women, unattached women, single mothers, women with disabilities, women of colour, immigrant women and Aboriginal women are groups that are more at risk for poverty than others (Morris, 2000).

Caregiving

Changes in the health care system and social services (e.g. shorter hospital stays, deinstitutionalization, more outpatient treatment) have increased the need for care at home (Cranswick, 1997). In 1996, 15% of all women between the ages of 25 and 54 provided both unpaid child care and care assistance to a senior. Only 9% of men in this age range provide such care (Statistics Canada, 2000).

Environmental Changes

Air, water and soil pollution affect the health of populations directly and indirectly (Zayed and Lefebvre, 1996). According to the World Health Organization (1997), poor environmental quality is responsible for approximately 25% of all preventable ill

health in the world today. Air pollution, for instance, has a measurable impact on health: in the 1990s, the rate of hospitalization for asthma increased by 27% for boys and by 18% for girls (Health Canada, 1997).

Technological Change

According to Human Resources Development Canada (2001), "the extensive and relatively new information technologies and telecommunications industry covers a range of occupations that did not exist a decade ago. This leading-edge industry has four components: software and computer services, manufacturing, communications and cable services, and multimedia." Information technology promises to continue to change existing jobs and create new kinds of jobs. Whether women and men are equally able over time to adapt to these changes in the workplace, and how they will affect their health, is not yet fully understood.

Biotechnology and Genetics

Health services, medical practice and agriculture are increasingly transformed by developments in biotechnology and genomics. The mapping of the human genome and a better understanding of the DNA structure of other living organisms have laid the basis for new developments and refinements in biotechnology such as cloning, stem cell research and genetic engineering (GE), the insertion of genes into plants and animals to create genetically modified organisms (GMOs). New food products are being developed through the use of genetically modified (GM) plants and related agro-chemicals, and through the genetic engineering of animals and aquaculture. Applications in health care include genetic tests, new types of drugs and vaccines, growth of tissue for transplants and experimental gene therapies.

While there is much promise for new diagnostics and treatments in certain areas, there are also many unknown risks about the potential health and environmental impacts of these technologies. They also raise social, ethical and legal issues.

Women have a particular stake in the applications of biotechnology and genomics. They are the majority of the world's farmers, especially poor farmers, and so are profoundly affected by agricultural biotechnologies. They are usually the ones who buy and prepare food for their families. Women are major users of health care services and of pharmaceutical products. Because of child-bearing, women often must make choices about, and undergo, prenatal or other genetic screening/testing. As primary, usually unpaid, caregivers of children, the sick, the elderly and persons with disabilities, women make decisions about, and administer, drugs or other treatments to others. Women are also the majority of workers in the health sector where the applications of biotechnology are concentrated (Working Group on Women, Health and New Genetics, 2000; Rochon Ford, 2001).

Commercialization

The relationship between private industry and researchers in universities and the effects of funding on research findings and publication is under debate. Another topical issue is

whether or not the commercialization of intellectual property should be a core mission of universities. The general public is being challenged to acquire more understanding of the significance of these issues for treatment choices, drug advertising and the generation of scientific knowledge. As citizens, patients, participants in clinical trials of drugs or treatments, and taxpayers, Canadians are directly affected by these issues.

Public Involvement

Effective and meaningful public involvement improves policy development, regulatory implementation and service delivery. There is a growing mandate for government to provide the public with increased access to information, and make it easier for people to become aware of opportunities to take part in the decision-making process. At the same time, opportunities for meaningful public involvement may be constrained by lack of knowledge about government decision-making processes, by geographic isolation and by lack of resources that enable participation.

Health Canada faces the ongoing challenge of monitoring all of these diverse social trends and assessing their health implications.